AUTHORIZATION OF MEDICAL RECORDS RELEASE FOR TRANSFER OF SERVICES

I, ____, parent and/or legal guardian of

____, date of birth, ______________ under the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164, authorize the Releasing Company, _______________________________________, to disclose and immediately release the information selected on this form, via fax, to the requesting Premier Pediatric Therapy Representative.

The medical records information to be released ranges from ______________ to ______________ during which time I certify that my child was under the Releasing Company's care.

I authorize Premier Pediatric Therapy to obtain the following information in order to continue with my child's continuity of care:

- Current or recent Evaluation or Re-evaluation
- Current Insurance Determination/Authorization letter of approved therapy
- Complete past and current medical records and information
- Other: ____

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I further understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____ ____________________

Signature of Patient Parent/Legal Guardian Signature Date

____ ____________________

Printed Name of Premier Pediatric Therapy Representative Job Title

Premier Pediatric Therapy
415 S First Street
Suite 300A
Lufkin, TX 75901
Phone: (832) 539-1632
Fax: (832) 539-1633